ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4497	A. BUILDING: _____ B. WING _____	C 10/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	1201 SOUTH 7TH AVENUE, SUITE 120 PHOENIX, AZ 85007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	Initial Comment An on-site investigation of complaints AZ00150955, AZ00150961, AZ00151004, AZ00151093, AZ00151139, AZ00151061, AZ00151203, AZ00151213, AZ00151220, AZ00151305, AZ00151307, AZ00151308, AZ00151319, AZ00151324, AZ00151371, AZ00151377, AZ00151405, AZ00151413, AZ00151427, AZ00151431, AZ00151459, AZ00151458, AZ00150858, AZ00151362, AZ00151566, AZ00151535, AZ00151554, AZ00151214, AZ00151663, AZ00151827 was conducted on October 18 and October 19, 2018 and off-site documentation review was conducted October 20, 2018. 55 of 77 allegations were able to be substantiated, 22 of 77 allegations were unable to be substantiated, and the following deficiencies were cited. Based on the allegations substantiated and deficient practices found at the facility, a significant risk of harm to the life, health and safety of residents was found and the Department called an Immediate Jeopardy (IJ) at this facility on October 19, 2018. The IJ was lifted on October 20, 2018. Alice Slaysman, State Licensing Surveyor Lauren Drucker, State Licensing Surveyor Tiffany Slater, State Licensing Surveyor Abby Ziegler, State Licensing Surveyor	X 000		
X 3EI	R9-10-703.C.1.l. Administration C. An administrator shall ensure that:	X 3EI		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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X 3EI	Continued From page 1 1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that: I. Cover a quality management program, including incident reports and supporting documentation; This RULE is not met as evidenced by: Based on record review and documentation review, the administrator failed to ensure policies and procedures were implemented to protect the health and safety of a resident to cover a quality management program, including incident reports and supporting documentation. Findings include: 1. A review of facility documentation revealed a policy and procedure manual dated August 2018. The manual included a policy titled, "SOUTHWEST KEY PROGRAMS/Office of Refugee Resettlement Significant Incident Report Policy". The policy stated, "Program Director, Assistant Program Director, Clinician or Caseworker will ensure that the requirement for required reports is met when a significant or serious incident report occurs with any child in the programs care: Significant incidents are incident reports that have a significant impact on the safety and welfare of the children in care....The following are incidents which will require notification and SIR report:...Medical or mental health emergencies...Any abuse or neglect incident handled under state law, and...Behavior incidents, including behavior that threatens the safety of the child, other children, or staff members, as well as disruptive, destructive or aggressive behavior problems."	X 3EI		

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X 3EI	Continued From page 2 2. A review of R20's medical record revealed a 1:1 observation log dated [redacted] 2018. The log included a note at [redacted] which stated, "Client went outside to patio, was trying to hug [redacted] was pushing [R20] away telling client to stop forcing hugs or [redacted]. Client was upset, started hitting [redacted] Client was tripping on [redacted] feet, staff was re-directing client. Client calmed down went to sit on dinning [sic] table." 3. A review of R20's electronic medical record revealed no documentation of a significant incident report for the aggressive behavior directed towards R20's [redacted] on [redacted] 2018. 4. A review of R20's electronic medical record revealed a UM [Unaccompanied Minor] informational incident report dated [redacted] 2018. The incident report stated, "[Youth care worker] was transporting minors from basement to 2nd floor. [Youth care worker] was directing minors into the elevator. [R20] went into the elevator trying to shove minors [R20] was passing with [R20's] elbow. When [R20] got to the back of the elevator [resident] called [R20] 'pendejo'. [R20] reacted by shoving [resident] with [R20's] elbow and grabbed at [resident's] face, causing a minor [redacted] on [resident's] [redacted] [Resident] then caught [R20's] left hand, bending [R20's] fingers back. [Youth care worker] intervened trying to separate minors. Incident was staff with on call clinician. Medical followed up with [resident] and was informed about [R20]." However, R20's electronic medical record did not include documentation of a significant incident report for the aggressive behavior. 5. A review of R20's electronic medical record revealed a UM informational incident report dated	X 3EI		

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X 3EI	Continued From page 3 [redacted] 2018. The incident report stated, "Minors... were playing with a stress ball when [resident] called [R20] 'Santa Claus'. As [resident] was being redirected, [R20] threw a sandal at [resident's] face." However, R20's electronic medical record did not include documentation of a significant incident report for the aggressive behavior.	X 3EI		
X 3FI	R9-10-703.C.2.c. Administration C. An administrator shall ensure that: 2. Policies and procedures for behavioral health services and physical health services are established, documented, and implemented to protect the health and safety of a resident that: c. Include when general consent and informed consent are required; This RULE is not met as evidenced by: Based on documentation review, record review, and interview, the administrator failed to ensure policies and procedures for behavioral health services were implemented to protect the health and safety of a resident included when general consent and informed consent were required. Findings include: 1. A review of the facility's policies and procedures revealed a policy titled, "Admission Policy." The policy stated, "Admission will not occur and services will not be provided unless general consent is obtained. Informed consent for services is obtained from the client and the client's guardian, custodian, or agent prior to a client receiving a specific treatment, or a change	X 3FI		

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X 3FI	Continued From page 4 in treatment occurring. Examples include, but are not limited to, changes in medication, for which informed consent has not yet been obtained, and/or similar circumstances." The policy and procedure manual indicated it was reviewed and approved August 2018. 2. A review of R1's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R1's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 3. A review of R2's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R2's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 4. A review of R2's electronic medical record revealed a medication order dated [redacted] 2018 for [redacted] one tablet by mouth in the morning. R2's medical record did not contain informed consent as outlined in the policies and procedures. 5. A review of R3's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R3's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 6. A review of R4's electronic medical record	X 3FI		

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X 3FI	Continued From page 5 (date of acceptance [redacted] 2018, date of discharge [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R4's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 7. A review of R5's electronic medical record (date of acceptance [redacted] 2017) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2017. However, R5's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2017. 8. A review of R6's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R6's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 9. A review of R7's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R7's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 10. A review of R8's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical Dental, and Mental Health Care" was dated [redacted] 2018. However, R8's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018.	X 3FI		

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X 3FI	Continued From page 6 11. A review of R9's electronic medical record (date of acceptance [redacted] 2018, date of discharge [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R9's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 12. A review of R10's electronic medical record (date of acceptance [redacted] 2018, date of discharge [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R10's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 018. 13. A review of R11's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R11's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 14. A review of R12's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R12's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 15. A review of R13's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R13's medical record revealed	X 3FI		

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X 3FI	Continued From page 7 an Individualized Service Plan which indicated services began on [redacted] 2018. 16. A review of R14's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R13's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 17. A review of R15's electronic medical record (date of acceptance [redacted] 2017) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2017. However, R14's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2017. 18. A review of R16's electronic medical record (date of acceptance [redacted] 2018, date of discharge [redacted] 2018) revealed no documentation or evidence to indicate general consent was given at the time of admission according to the facility's policies and procedures. R16's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 19. A review of R17's electronic medical record (date of acceptance [redacted] 2018, date of discharge [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R17's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 20. A review of R18's electronic medical record	X 3FI		

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X 3FI	Continued From page 8 (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R18's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 21. A review of R19's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R19's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 22. A review of R20's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R20's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 23. A review of R21's electronic medical record (date of acceptance [redacted] 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was [redacted] 2018. However, R21's medical record revealed an Individualized Service Plan which indicated services began on [redacted] 2018. 24. A review of R25's electronic medical record (date of acceptance [redacted] 2018, 2018) revealed a form titled, "Authorization for Medical, Dental, and Mental Health Care" which was dated [redacted] 2018. However, R25's medical record revealed an Individualized Service Plan which indicated services began on [redacted]	X 3FI		

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X 3FI	Continued From page 9 2018. 25. In an interview, E4 reported the "Authorization for Medical, Dental, and Mental Health Care" form was the general consent. E4 reported general consent was obtained within 24 hours of admission. E4 acknowledged the general consent was not obtained at admission and prior to providing services and acknowledged informed consent was not obtained prior to changes in medications.	X 3FI		
X 3NP	R9-10-703.H.1-6 Administration H. If an administrator has a reasonable basis, according to A.R.S. §§ 13-3620 or 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving services from a behavioral health residential facility's employee or personnel member, the administrator shall: 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation; 2. Report the suspected abuse, neglect, or exploitation of the resident: a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or b. For a resident under 18 years of age, according to A.R.S. § 13-3620; 3. Document: a. The suspected abuse, neglect, or exploitation; b. Any action taken according to subsection (H)(1); and c. The report in subsection (H)(2); 4. Maintain the documentation in subsection (H)(3) for at least 12 months after the date of the report in subsection (H)(2); 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the	X 3NP		

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X 3NP	Continued From page 10 following information within five working days after the report required in (H)(2): a. The dates, times, and description of the suspected abuse, neglect, or exploitation; b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition; c. The names of witnesses to the suspected abuse, neglect, or exploitation; and d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and 6. Maintain a copy of the documented information required in subsection (H)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated. This RULE is not met as evidenced by: Based on record review and documentation review, the administrator failed to ensure abuse that occurred on the premises was reported according to A.R.S. § 13-3620 and investigated. Findings include: 1. A.R.S. § 13-3620 states, "A. Any person who reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect that appears to have been inflicted on the minor by other than accidental means or that is not explained by the available medical history as being accidental in nature or who reasonably believes there has been a denial or deprivation of necessary medical treatment or surgical care or nourishment with the intent to cause or allow the death of an infant who is protected under section 36-2281 shall immediately report or cause reports to be made	X 3NP		

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X 3NP	Continued From page 11 of this information to a peace officer, to the department of child safety..." 2. A review of facility documentation revealed a policy and procedure manual revised August 2018. The manual included a policy and procedure titled, "Incident Reporting" which stated, "The Program Director shall ensure that a report is written when the following incidents occur. This list is not inclusive...Allegations or occurrences of physical abuse, neglect, exploitation, or other violations of client rights...Accidents and injuries...Illegal or violent behavior.... The Program Director or designee in coordination with the Regional Executive Director shall investigate all allegations of abuse, neglect and exploitation. They shall also notify proper authorities including Department of Child Safety in writing within 24 hours of an incident. Local law enforcement shall also be contacted if necessary." 3. A review of R20's medical record revealed a 1:1 observation log dated [redacted] 2018. The log included a note at [redacted] which stated, "Client went outside to patio, was trying to hug [redacted] was pushing [R20] away telling client to stop forcing hugs on [redacted] Client was upset, started hitting [redacted] Client was tripping on [redacted] feet, staff was re-directing client. Client calmed down went to sit on dinning [sic] table." However, a review of R20's medical record revealed the record did not include documentation to indicate the incident was reported in accordance with A.R.S. § 13-3620 or was investigated. 4. A review of R20's electronic medical record revealed a UM [Unaccompanied Minor] informational incident report dated [redacted]	X 3NP		

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X 3NP	Continued From page 12 2018. The incident report stated, "Minors... were playing with a stress ball when [resident] called [R20] 'Santa Claus'. As [resident] was being redirected, [R20] threw a sandal at [resident's] face." However, the incident report did not include documentation to indicate the incident was reported in accordance with A.R.S. § 13-3620 or was investigated 5. A review of R20's electronic medical record revealed a UM informational incident report. The incident report stated, "[Youth care worker] was transporting minors from basement to 2nd floor. [Youth care worker] was directing minors into the elevator. [R20] went into the elevator trying to shove minors [R20] was passing with [R20's] elbow. When [R20] got to the back of the elevator [resident] called [R20] 'pendejo'. [R20] reacted by shoving [resident] with [R20's] elbow and grabbed at [resident's] face, causing a minor [redacted] on [resident's] [redacted] [Resident] then caught [R20's] left hand, bending [R20's] fingers back. [Youth care worker] intervened trying to separate minors. Incident was staff with on call clinician. Medical followed up with [resident] and was informed about [R20]." However, the incident report did not include documentation to indicate the incident was reported in accordance with A.R.S. § 13-3620 or was investigated.	X 3NP		
X 4BE	R9-10-704.2.b. Quality Management An administrator shall ensure that: 2. A documented report is submitted to the governing authority that includes: b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and	X 4BE		

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X 4BE	Continued From page 13 This RULE is not met as evidenced by: Based on document review and interview, the administrator failed to ensure a documented quality management report was submitted to the governing authority that included any change made or action taken as a result of the identification of a concern about the deliver of services related to resident care. Findings include: 1. A review of policies and procedures contained a policy titled, "Quality Management" that revealed steps to gather and evaluate incidents relating to resident care and submission of a final report. The policy stated, "...7. The Program Director will submit the final report to... on any change that impacted the services of the client as a result of the reported incident...The final report will note the following information: b. The changes made or action taken as a result of the identified concern about the delivery of services related to each client." 2. A review of the quality management report for the fiscal year October 1, 2017 - September 30, 2018 stated the following: First Quarter - "Significant Findings and Events," under the category of Abuse or Neglect in ...Care a total of 17 significant incident reports. Under the category of "Major Behavioral Incidents that threaten safety" a total of 60 significant incident reports. Under the category of "Other" a total of 157 significant incident reports. The report did not include any changes made or action taken. 3. A review of the quality management report for the fiscal year January 1, 2018 - March 31, 2018 stated the following: Second Quarter - "Significant Findings and	X 4BE		

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X 4BE	Continued From page 14 Events," under the category of Abuse or Neglect in ...Care a total of 13 significant incident reports. Under the category of "Major Behavioral Incidents that threaten safety" a total of 94 significant incident reports. Under the category of "Other" a total of 220 significant incident reports. The report did not include any changes made or action taken. 4. A review of the quality management report for the fiscal year April 1, 2018 - June 30, 2018 stated the following: Third Quarter - "Significant Findings and Events," under the category of Abuse or Neglect in ...Care a total of 15 significant incident reports. Under the category of "Major Behavioral Incidents that threaten safety" a total of 89 significant incident reports. Under the category of "Other" a total of 236 significant incident reports. The report did not include any changes made or action taken. 5. A review of the quality management report for the fiscal year January 1, 2018 - March 31, 2018 stated the following: Second Quarter - "Significant Findings and Events," under the category of Abuse or Neglect in ...Care a total of 13 significant incident reports. Under the category of "Major Behavioral Incidents that threaten safety" a total of 94 significant incident reports. Under the category of "Other" a total of 220 significant incident reports. The report did not include any changes made or action taken. 6. A review of the quality management report for the fiscal year July 1, 2018 - September 30, 2018 stated the following: Fourth Quarter - "Significant Findings and Events," under the category of Abuse or Neglect in ...Care a total of 48 significant incident reports.	X 4BE		

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X 4BE	Continued From page 15 Under the category of "Major Behavioral Incidents that threaten safety" a total of 150 significant incident reports. Under the category of "Other" a total of 205 significant incident reports. The report did not include any changes made or action taken. 7. In an interview, O1 reported changes were implemented as incidents are reviewed and they submit all information to the governing board as required by their contract. However, the quality management report, as required by licensing, does not contain all the required information.	X 4BE		
X 6CB	R9-10-706.B.2.a-b. Personnel B. An administrator shall ensure that: 2. A personnel member's skills and knowledge are verified and documented: a. Before the personnel member provides physical health services or behavioral health services, and b. According to policies and procedures; and This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to ensure a personnel members' skills, and knowledge were verified and documented before the personnel member provided services and according to policies and procedures for three of twenty-five sampled records. Findings include: 1. A review of E19's (hire date: December 26,	X 6CB		

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X 6CB	Continued From page 16 2017) personnel record revealed a document titled, "UM [Unaccompanied Minor] Reference Check Guidelines Conducted by Phone." The document states, "Prior to hiring a prospective candidate for employment, 2 professional background checks from prior employers must be conducted. These checks may not be from personal friends or family members, but rather ...to obtain information on prior job performance., the reference must be about prior work experience. A minimum of two attempted contacts must be provided to each reference 24 hours apart and properly documented below." 2. E19's personnel record contained a reference check form for one individual who was attempted to be contacted on January 16, 2018 at 2:17 pm, twenty-one days after the date of hire. One attempt was made and the notes stated, "no answer." An additional reference check form for E19 was conducted January 16, 2018 at 2:15 pm. One attempt was made and the notes stated, "no answer - current employee." 3. A review of E20's (hire date: December 18, 2017) personnel record revealed the same aforementioned document titled, "UM Reference....." The record contained a reference check form for one individual who was contacted on May 28, 2018, one hundred sixty-one days after the date of hire. The document did not indicate if this was a personal or professional reference. Upon notifying the administrator, two additional references were made on the day of the survey, October 18, 2018, to two professional references. 4. A review of E22's (hire date: January 30, 2017) personnel record revealed the same aforementioned document titled, "UM	X 6CB		

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X 6CB	Continued From page 17 Reference....." The record contained a reference check form for one individual who was contacted on October 3, 2017, at 12:35 pm, two hundred forty-six days after the date of hire. This reference was provided by E22, who noted the reference was an "amigo." An additional attempt was made to another reference who was noted by E22 as an "amiga." Attempts to contact this reference was made on October 3, 2017 at 12:06 pm and October 4, 2017, at 10:32 am. The document noted, "no answer." Upon notifying the administrator, two additional references were made on the day of the survey, October 18, 2018 to two professional references. 5. In an interview, O1 reported a new system had been implemented as per the previous on site survey on August 9, 2018, in the plan of correction submitted to the Department to ensure the facility complies with their guidelines on conducting references.	X 6CB		
X 6CP	R9-10-706.B.3.a-c Personnel B. An administrator shall ensure that: 3. Sufficient personnel members are present on a behavioral health residential facility's premises with the qualifications, experience, skills, and knowledge necessary to: a. Provide the services in the behavioral health residential facility's scope of services, b. Meet the needs of a resident, and c. Ensure the health and safety of a resident. This RULE is not met as evidenced by: Based on observation, documentation review, record review, and interview, the administrator failed to ensure sufficient personnel members were present on the behavioral health residential	X 6CP		

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X 6CP	Continued From page 18 facility's premises with the qualifications, experience, skills, and knowledge necessary to meet the needs of a resident and ensure the health and safety of a resident. Findings include: 1. The surveyors observed a surveillance video of an incident that occurred on [redacted] 2018. The surveillance video revealed E14 grabbed R17's left arm and pulled R17 out of the bedroom R17 was attempting to walk into. R17 slid onto the floor, inched towards the bedroom, and kicked E14. E14 then dragged R17 out of the bedroom by R17's left arm. E14 later picked R17 up under R17's arms, carried R17 into the hallway, and set R17 onto the floor. R17 was on the floor for the majority of the video trying to kick E14, who was standing over R17. E14 was observed grabbing and holding onto R17's legs, feet, and ankles multiple times. In one instance, E14 crossed and held R17's ankles together for several seconds. Shortly after letting go, E14 pushed R17's legs to the floor. R17 later was on the ground in the entryway of the bedroom when E14 grabbed both of R17's legs and dragged R17 out of the bedroom. R17's head, neck, and shoulders were on the floor as R17 was being dragged. Towards the end of the video clip, E14 was observed picking R17 up, carrying R17 through the hallway, and setting R17 down as R17 was starting to fall. The video showed five employees were surrounding the resident at that time. 2. The surveyors observed a few surveillance videos of an incident that occurred on [redacted] 2018. The first video showed R21 running down the hallway attempting to go into another bedroom. Two employees were blocking entrance	X 6CP		

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X 6CP	Continued From page 19 into the bedroom. R21 made multiple attempts to enter the bedroom throughout the 15 minute 55 second video. R21 went into the bedroom several times. The second video showed E15 grab R21 by the right arm. When R21 tried to go back into the bedroom E15 pulled R21's arm. E15 later held R21 from behind while they were in a standing position. E15's arms were around R21's abdomen. The third video started with R21 in the hold. E15 then picked up R21 while in the hold position and carried R21 down the hallway. 3. A review of E14's personnel record revealed a corrective action form showing E14 was suspended pending an investigation. The form documented it was alleged that E14 had inappropriate contact with R17. It further documented E14 reported E14 was supervising R17 in R17's dorm and R17 was "doing some paper planes," then R17 walked out of R17's dorm and was heading to R17's [redacted] dorm. E14 reported trying to block the dorm entrance and grabbed R17's left hand by the wrist to avoid R17 getting inside. There was nothing documented regarding E14 pulling, dragging, holding, and carrying R17. 4. A review of facility documentation revealed a significant incident report (SIR) dated [redacted] 2018. The SIR documented o[redacted] 2018, E15 used haptics to try and lead R21 back to R21's bedroom. When this strategy did not work E15 used "CPI Low Level Body Hug Restraint position for approximately 120 seconds." The SIR did not document that E15 carried R21 down the hallway. 5. A review of facility documentation revealed a policy and procedure manual revised August 2018. The manual included a section titled	X 6CP		

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X 6CP	Continued From page 20 "Program Description," which revealed "All employees are trained in Non-Violent Crisis Intervention...in order to ensure that physical intervention in response to emergencies is safe and secure for all clients and employees." 6. A review of facility documentation revealed a Participant Workbook for CPI Nonviolent Crisis Intervention with pictures of approved physical interventions. The workbook revealed pulling, dragging, and carrying were not approved physical techniques. The workbook stated "The principles surround a values base concerned with ensuring that the rights of people are maintained and that physical interventions are used to protect and not used in any way that could be viewed as degrading or abusive." It further documented "It is essential that physical intervention is used only as a last resort to manage risk behavior when all other reasonable, non-physical approaches have been exhausted and failed to prevent the situation from escalating...Physical interventions should never be used to enforce rules or as a punishment..." 7. A review of the personnel records for E14 and E15 showed they completed CPI Nonviolent Crisis Intervention training prior to the incidents. E15's personnel record revealed no evidence of counseling or a corrective action taken following the incident with R21. E15's date of termination was October 2, 2018. 8. In an interview, O1 reported E14 resigned during the investigation. O1 later reported they felt E14 could have done things differently and they were using the video for staff training. 9. In an interview, O1 acknowledged E15 did not have evidence of counseling or any corrective	X 6CP		

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X 6CP	Continued From page 21 actions. O1 explained E15 left on E15's own.	X 6CP		
X 6FA	R9-10-706.F.1-2. Personnel F. An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with residents, provides evidence of freedom from infectious tuberculosis: 1. On or before the date the individual begins providing services at or on behalf of the behavioral health residential facility, and 2. As specified in R9-10-113. This RULE is not met as evidenced by: Based on documentation review, record review, and interview, the administrator failed to ensure a personnel member expected to have more than eight hours of direct interaction per week with residents provided evidence of freedom from infectious tuberculosis (TB) as specified in R9-10-113 for three of twenty-five sampled records. Findings include: 1. A review of documentaion revealed a policy titled, "Staffing Requirements Policy," which stated, "...At the starting date of employment and every 12 months thereafter, all staff members submit [documentation]as evidence of freedom from infectious pulmonary tuberculosis..." 2. A review of E14's medical record (hire date: [redacted] 2015, termination date: [redacted] 2018) revealed a copy of a chest x-ray	X 6FA		

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X 6FA	Continued From page 22 completed [redacted] 2016 verifying freedom from TB. The record had no subsequent screening for TB. 3. A review of E17's medical record (hire date: [redacted] 2016) revealed copies of TB screening completed [redacted] 2016, and [redacted] 2018. The screening completed on [redacted] 2018 was four days after the required timeframe's. 4. A review of E21's medical record (hire date: [redacted] 2015) revealed a copy of a chest x-ray completed [redacted] 2016, and another x-ray completed [redacted] 2018. The record had no documentaion of TB screening on or before the personnel member began providing services or a screening for TB twelve months after the initial TB screening. 5. In an interview, O1 reported a new system had been implemented as per the previous on site survey on August 9, 2018, in the plan of correction submitted to the Department to ensure the facility does not miss due dates.	X 6FA		
X 7BE	R9-10-707.A.7.a. Admission; Assessment A. An administrator shall ensure that: 7. If a behavioral health assessment is conducted by a: a. Behavioral health technician or registered nurse, within 24 hours a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the resident; or	X 7BE		

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X 7BE	Continued From page 23 This RULE is not met as evidenced by: Based on documentation review, record review, and interview, the administrator failed to ensure a behavioral health assessment conducted by a behavioral health technician (BHT) was reviewed and signed by a behavioral health professional (BHP) within 24 hours to ensure the behavioral health assessment identified the behavioral health services needed by the resident for, 18 of 22 current residents sampled. Findings include: 1. A review of the facility's policies and procedures revealed a policy titled, "Personnel Qualifications Policy." The policy stated, "The Lead Clinician shall have a Master's degree in social work (MSW) and 5 years of postgraduate direct service delivery experience; or a Master's degree in psychology, counseling, or other relevant behavioral science in which clinical training and experience is a program requirement. Arizona State Licensure and supervisory experience are also required. The Lead Clinician will be required to have the skills and knowledge necessary to: - Provide the behavioral health services that the agency is authorized to provide. - Conduct and document mental health assessments." The policy and procedure manual indicated it was reviewed and approved in August 2018. 2. A review of R1's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP.	X 7BE		

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X 7BE	Continued From page 24 3. A review of R2's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 4. A review of R3's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 5. A review of R5's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2017, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 6. A review of R6's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 7. A review of R7's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 8. A review of R8's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 9. A review of R11's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT.	X 7BE		

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X 7BE	Continued From page 25 However, the behavioral health assessment was not reviewed and signed by a BHP. 10. A review of R12's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 11. A review of R13's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 12. A review of R14's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 13. A review of R15's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2017, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 14. A review of R18's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 15. A review of R19's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 16. A review of R20's electronic medical record	X 7BE		

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	BH4497	A. BUILDING: _____ B. WING _____	C 10/20/2018

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X 7BE	Continued From page 26 revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 17. A review of R21's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 18. A review of R22's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by E25, a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 19. A review of R26's electronic medical record revealed a behavioral health assessment conducted on [redacted] 2018, by a BHT. However, the behavioral health assessment was not reviewed and signed by a BHP. 20. In an interview, E4 reported the behavioral health assessments were conducted by the case managers upon admission and acknowledged the assessments were not reviewed and signed by a BHP.	X 7BE		
X 8AA	R9-10-708.A.1. Treatment Plan A. An administrator shall ensure that a treatment plan is developed and implemented for each resident that: 1. Is based on the medical history and physical examination or nursing assessment required in R9-10-707(A)(5) or (E)(1) and the behavioral health assessment required in R9-10-707(A)(8) or(9) and on-going changes to the behavioral	X 8AA		

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X 8AA	Continued From page 27 health assessment of the resident; This RULE is not met as evidenced by: Based on documentation review, record review, and interview, the administrator failed to ensure a treatment plan was developed and implemented for each resident that was based on the behavioral health assessment and on-going changes to the behavioral health assessment, for one of 22 current residents sampled. Findings include: 1. A review of the facility's policies and procedures revealed a policy titled, "Treatment Planning Policy." The policy stated, "3. Within 24 hours of arriving at the facility, the clients will undergo a Mental Health Screening (MHS) performed by an assigned clinician which will further assess the clients' mental health/behavioral health needs and will assist in the development of the client's Individual Service Plan (ISP), which is the treatment planning mechanism used by Southwest Key Programs. 4. The MHS will aim to identify the following elements in order to develop a : a. Extreme mental health/behavioral health issues. b. History of abuse and/or neglect. c. Information regarding family structure and dynamics. d. Developmental issues necessitating elevated and/or ongoing treatment. e. Any other issues of clinical/behavioral health concern. 5. In addition to any information obtained during the MHS, the clinician and/or case manager shall collect all available and relevant information in order to assess clients' needs and develop an	X 8AA		

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X 8AA	Continued From page 28 appropriate treatment plan. " The policy and procedure manual indicated it was reviewed and approved in August 2018. 2. A review of R2's electronic medical record revealed a document titled, "UAC Assessment" dated [redacted] 2018. The assessment indicated R2 had a history of [redacted] The record also contained a "UM[Unaccompanied Minor] Clinical Mental Health Admission Screening" dated [redacted] 2018 which indicated R2 had [redacted] 3. A review of R2's Individual Service Plan (ISP) dated [redacted] 2018 revealed no documentation of evidence to indicate [redacted] would be addressed as part of the treatment plan as outlined in the policies and procedures. 4. A review of R2's electronic medical record revealed a psychiatric evaluation from [redacted] Hospital dated [redacted] 2018 which stated, [redacted] The document also revealed a medication order for [redacted] one table by mouth in the morning" for a diagnosis o[redacted] 5. A review of R2's ISP dated [redacted] 2018 revealed no documentation of evidence of [redacted] medications for [redacted] would be addressed as part of the treatment plan as outlined in the policies and procedures. The service plan was reviewed and signed by a BHP on [redacted] 2018.	X 8AA		

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X 8AU	Continued From page 29	X 8AU		
X 8AU	R9-10-708.A.4.a. Treatment Plan A. An administrator shall ensure that a treatment plan is developed and implemented for each resident that: 4. Includes: a. The resident's presenting issue; This RULE is not met as evidenced by: Based on documentation review, record review, and interview, the administrator failed to ensure a treatment plan was developed and implemented for each resident which included the resident' presenting issue for 20 of 22 current residents sampled. Findings include: 1. A review of the facility's policies and procedures revealed a policy titled, "Treatment Planning Policy." The policy stated, "3. Within 24 hours of arriving at the facility, the clients will undergo a Mental Health Screening (MHS) performed by an assigned clinician which will further assess the clients' mental health/behavioral health needs and will assist in the development of the client's Individual Service Plan (ISP), which is the treatment planning mechanism used by Southwest Key Programs. 4. The MHS will aim to identify the following elements in order to develop a : a. Extreme mental health/behavioral health issues. b. History of abuse and/or neglect. c. Information regarding family structure and dynamics. d. Developmental issues necessitating elevated and/or ongoing treatment. e. Any other issues of clinical/behavioral health	X 8AU		

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X 8AU	Continued From page 30 concern. 5. In addition to any information obtained during the MHS, the clinician and/or case manager shall collect all available and relevant information in order to assess clients' needs and develop an appropriate treatment plan. " The policy and procedure manual indicated it was reviewed and approved in August 2018. 2. A review of R1's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R1's presenting issue(s). 3. A review of R2's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R2's presenting issue(s). 4. A review of R3's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R3's presenting issue(s). 5. A review of R5's medical record revealed a treatment plan dated [redacted] 2017. The treatment plan contained no documentation of evidence to indicate R5's presenting issue(s). 6. A review of R6's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R6's presenting issue(s). 7. A review of R7's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R7's presenting issue(s). 8. A review of R8's medical record revealed a	X 8AU		

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X 8AU	Continued From page 31 treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R8's presenting issue(s). 9. A review of R11's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R11's presenting issue(s). 10. A review of R12's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R12's presenting issue(s). 11. A review of R13's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R13's presenting issue(s). 12. A review of R14's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R14's presenting issue(s). 13. A review of R15's medical record revealed a treatment plan dated [redacted] 2017. The treatment plan contained no documentation of evidence to indicate R15's presenting issue(s). 14. A review of R18's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R18's presenting issue(s). 15. A review of R19's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R19's presenting issue(s). 16. A review of R20's medical record revealed a	X 8AU		

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X 8AU	Continued From page 32 treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R20's presenting issue(s). 17. A review of R21's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R21's presenting issue(s). 18. A review of R25's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R25's presenting issue(s). 19. A review of R26's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R26's presenting issue(s). 20. A review of R27's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R27's presenting issue(s). 21. A review of R31's medical record revealed a treatment plan dated [redacted] 2018. The treatment plan contained no documentation of evidence to indicate R31's presenting issue(s). 22. In an interview, E4 reported the clinicians were "supposed to" include the presenting issues on the treatment plans. E4 also reported when a resident has an Significant Incident Report, the goals on the treatment plan would be updated. E4 acknowledged the treatment plans did not include each resident's presenting issues.	X 8AU		
X 8CA	R9-10-708.A.5. Treatment Plan	X 8CA		

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X 8CA	Continued From page 33 A. An administrator shall ensure that a treatment plan is developed and implemented for each resident that: 5. If the treatment plan was completed by a behavioral health technician, is reviewed and signed by a behavioral health professional within 24 hours after the completion of the treatment plan to ensure that the treatment plan is complete and accurate and meets the resident's treatment needs; and This RULE is not met as evidenced by: Based on documentation review, record review, and interview, the administrator failed to ensure a treatment plan developed by a behavioral health technician (BHT) was reviewed and signed by a behavioral health professional (BHP) within 24 hours to ensure the treatment plan was complete and accurate and met the residents' needs for 20 of 22 current residents sampled. Findings include: 1. A review of the facility's policies and procedures revealed a policy titled, "Treatment Planning Policy." The policy stated, "3. Within 24 hours of arriving at the facility, the clients will undergo a Mental Health Screening (MHS) performed by an assigned clinician which will further assess the clients' mental health/behavioral health needs and will assist in the development of the client's Individual Service Plan (ISP), which is the treatment planning mechanism used by Southwest Key Programs...9. The Lead Clinician or another qualified designee shall ensure that the MHS and ISP process is conducted under the supervision of a Lead Clinician or another qualified behavioral health professional." The policy and procedure	X 8CA		

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X 8CA	Continued From page 34 manual indicated it was reviewed and approved in August 2018. 2. A review of R1's medical record revealed a treatment plan conducted on [redacted]2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 3. A review of R2's medical record revealed a treatment plan conducted on [redacted]2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 4. A review of R3's medical record revealed a treatment plan conducted on [redacted]2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 5. A review of R5's medical record revealed a treatment plan conducted on [redacted]2017, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 6. A review of R6's medical record revealed a treatment plan conducted on [redacted]2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 7. A review of R7's medical record revealed a treatment plan conducted on [redacted]2018 by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 8. A review of R8's medical record revealed a treatment plan conducted on [redacted]2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 9. A review of R11's medical record revealed a treatment plan conducted on [redacted]2018,	X 8CA		

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X 8CA	Continued From page 35 by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 10. A review of R12's medical record revealed a treatment plan conducted on [redacted] 2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 11. A review of R13's medical record revealed a treatment plan conducted on [redacted] 2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 12. A review of R14's medical record revealed a treatment plan conducted on [redacted] 2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 13. A review of R15's medical record revealed a treatment plan conducted on [redacted] 2017, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 14. A review of R18's medical record revealed a treatment plan conducted on [redacted] 2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 15. A review of R19's medical record revealed a treatment plan conducted on [redacted] 2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 16. A review of R20's medical record revealed a treatment plan conducted on [redacted] 2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 17. A review of R21's medical record revealed a treatment plan conducted on [redacted] 2018, by a	X 8CA		

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X 8CA	Continued From page 36 BHT. However, the treatment plan was not reviewed and signed by a BHP. 18. A review of R25's medical record revealed a treatment plan conducted on [redacted]2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 19. A review of R26's medical record revealed a treatment plan conducted on [redacted] 2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 20. A review of R27's medical record revealed a treatment plan conducted on [redacted] 2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 21. A review of R31's medical record revealed a treatment plan conducted on [redacted] 2018, by a BHT. However, the treatment plan was not reviewed and signed by a BHP. 22. In an interview, E4 reported the BHP's did not begin reviewing and signing the treatment plans unti[redacted] 2018. E4 acknowledged the treatment plans above were not reviewed and signed by a BHP as required.	X 8CA		
X11AU	R9-10-711.B.1. Resident Rights B. An administrator shall ensure that: 1. A resident is treated with dignity, respect, and consideration; This RULE is not met as evidenced by: Based on documentation review and observation, the administrator failed to ensure a resident was	X11AU		

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X11AU	Continued From page 37 treated with dignity, respect, and consideration. Findings include: 1. A review of the facility's policies and procedures revealed a policy titled, "Client Rights." The policy stated, "ALL CLIENTS SHALL BE AFFORDED THE FOLLOWING BASIC RIGHTS: 1. To be treated with dignity, respect, and consideration." The policy and procedure manual indicated it was reviewed and approved in August 2018. 2. The surveyors observed a surveillance video of an incident that occurred on [redacted] 2018. The surveillance video revealed E19 reached into the front pocket of R1's pants to remove a deck of cards. 3. A review of facility documentation revealed a significant incident report (SIR) dated [redacted] 2018. The SIR stated, "[E21] reported around [redacted] or [redacted] 2018 that [R1]was in the library and that [R1] was not following instructions. [E21] reported that Teacher Assistant (TA), [E19] redirected [R1] and informed [R1] [R1] could not play with the playing cards while in the class. [R1] did not follow instructions and ignored the teacher [E21]. [E21] told [R1] to give [E21] the cards minor refused and placed them in [R1's] front right pocket. [R1] reported that [E21] grabbed [R1] by [R1's] forearm and placed [E21's] hand into [R1's] front pocket. [R1] reported that [R1] felt fearful when [E21] grabbed [R1] as it caused discomfort and pain. [R1] reported that the staff told [R1] I have more strength than you. [R1] stated that [R1] also felt uncomfortable due to staff touching [R1's genitals] while having [E21's] hand in [R1's] pocket. [R1] has acknowledged that the teacher's intention was to remove the	X11AU		

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X11AU	Continued From page 38 playing card from the pocket and the touching of [R1's] private area occurred during the process of removal of the cards. When disclosing the situation to Clinician [R1] reported that [R1] feels this is a PREA [Prison Rape Elimination Act] since [R1] felt that the staff [E1] inappropriately touched [R1's] genitals. [R1] acknowledged that [R1] should have followed directions however the teacher should not have placed [E21's] hands on [R1]. [R1] is stable at the moment." 4. The surveyors observed a surveillance video of an incident that occurred on [redacted] 2018. The surveillance video revealed E14 grabbed R17's left arm and pulled R17 out of the bedroom R17 was attempting to walk into. R17 slid onto the floor, inched towards the bedroom, and kicked E14. E14 then dragged R17 out of the bedroom by R17's left arm. E14 later picked R17 up under R17's arms, carried R17 into the hallway, and set R17 onto the floor. R17 was on the floor for the majority of the video trying to kick E14, who was standing over R17. E14 was observed grabbing and holding onto R17's legs, feet, and ankles multiple times. In one instance, E14 crossed and held R17's ankles together for several seconds. Shortly after letting go, E14 pushed R17's legs to the floor. R17 later was on the ground in the entryway of the bedroom when E14 grabbed both of R17's legs and dragged R17 out of the bedroom. R17's head, neck, and shoulders were on the floor as R17 was being dragged. Towards the end of the video clip, E14 was observed picking R17 up, carrying R17 through the hallway, and setting R17 down as R17 was starting to fall. The video showed five employees were surrounding the resident at that time. 5. The surveyors observed a few surveillance	X11AU		

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	BH4497	A. BUILDING: _____ B. WING _____	C 10/20/2018

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X11AU	Continued From page 39 videos of an incident that occurred on [redacted] 2018. The first video showed R21 running down the hallway attempting to go into another bedroom. Two employees were blocking entrance into the bedroom. R21 made multiple attempts to enter the bedroom throughout the 15 minute 55 second video. R21 went into the bedroom several times. The second video showed E15 grab R21 by the right arm. When R21 tried to go back into the bedroom E15 pulled R21's arm. E15 later held R21 from behind while they were in a standing position. E15's arms were around R21's abdomen. The third video started with R21 in the hold. E15 then picked up R21 while in the hold position and carried R21 down the hallway.	X11AU		
X11CO	R9-10-711.B.2.i. Resident Rights B. An administrator shall ensure that: 2. A resident is not subjected to: i. Restraint; This RULE is not met as evidenced by: Based on documentation review, observation, record review and interview, the administrator failed to ensure a resident was not subjected to restraint. Findings include: 1. R9-10-101.178 defines "Restraint" to mean any physical or chemical method of restricting a patient's freedom of movement, physical activity, or access to the patient's own body. 2. A review of the facility's policies and procedures revealed a policy titled, "Client	X11CO		

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X11CO	Continued From page 40 Rights." The policy stated, "ALL CLIENTS SHALL BE AFFORDED THE FOLLOWING BASIC RIGHTS:..19. To be free from:... .i. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation." The policy and procedure manual indicated it was reviewed and approved in August 2018. 3. The surveyors observed a surveillance video of an incident that occurred on [redacted] 2018. The surveillance video revealed E14 grabbed R17's left arm and pulled R17 out of the bedroom R17 was attempting to walk into. R17 slid onto the floor, inched towards the bedroom, and kicked E14. E14 then dragged R17 out of the bedroom by R17's left arm. E14 later picked R17 up under R17's arms, carried R17 into the hallway, and set R17 onto the floor. R17 was on the floor for the majority of the video trying to kick E14, who was standing over R17. E14 was observed grabbing and holding onto R17's legs, feet, and ankles multiple times. In one instance, E14 crossed and held R17's ankles together for several seconds. Shortly after letting go, E14 pushed R17's legs to the floor. R17 later was on the ground in the entryway of the bedroom when E14 grabbed both of R17's legs and dragged R17 out of the bedroom. R17's head, neck, and shoulders were on the floor as R17 was being dragged. Towards the end of the video clip, E14 was observed picking R17 up, carrying R17 through the hallway, and setting R17 down as R17 was starting to fall. The video showed five employees were surrounding the resident at that time. 4. The surveyors observed a few surveillance videos of an incident that occurred on [redacted] 2018. The first video showed R21 running down the hallway attempting to go into another	X11CO		

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X11CO	Continued From page 41 bedroom. Two employees were blocking entrance into the bedroom. R21 made multiple attempts to enter the bedroom throughout the 15 minute 55 second video. R21 went into the bedroom several times. The second video showed E15 grab R21 by the right arm. When R21 tried to go back into the bedroom E15 pulled R21's arm. E15 later held R21 from behind while they were in a standing position. E15's arms were around R21's abdomen. The third video started with R21 in the hold. E15 then picked up R21 while in the hold position and carried R21 down the hallway. 5. A review of E14's personnel record revealed a corrective action form showing E14 was suspended pending an investigation. The form documented it was alleged that E14 had inappropriate contact with R17. It further documented E14 reported E14 was supervising R17 in R17's dorm and R17 was "doing some paper planes," then R17 walked out of R17's dorm and was heading to R17's [redacted] dorm. E14 reported trying to block the dorm entrance and grabbed R17's left hand by the wrist to avoid R17 getting inside. There was nothing documented regarding E14 pulling, dragging, holding, and carrying R17. 6. A review of facility documentation revealed a significant incident report (SIR) dated [redacted] 2018. The SIR documented on [redacted] 2018, E15 used haptics to try and lead R21 back to R21's bedroom. When this strategy did not work E15 used "CPI Low Level Body Hug Restraint position for approximately 120 seconds." The SIR did not document that E15 carried R21 down the hallway. 7. The observed video surveillance revealed E14 and E15 used physical methods of restricting the	X11CO		

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X11CO	Continued From page 42 residents' freedom of movement and physical activity. 8. In an interview, O1 reported E14 resigned during the investigation. O1 later reported they felt E14 could have done things differently and they were using the video for staff training.	X11CO		
X12II	R9-10-712.C.22.d.i-ii. Medical Records C. An administrator shall ensure that a resident's medical record contains: 22. Documentation of medication administered to the resident that includes: d. For a psychotropic medication, when administered initially or on a PRN basis: i. An assessment of the resident's behavior before administering the psychotropic medication, and ii. The effect of the psychotropic medication administered; This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to ensure for one resident sampled receiving psychotropic medications, the resident's medical record contained an assessment of the resident's behavior before initially administering the psychotropic medication and the effect of the psychotropic medication administered. Findings include: 1. A review of R2's medical record (date of acceptance [redacted] 2018) revealed a	X12II		

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X12II	Continued From page 43 medication order dated [redacted] 2018, for [redacted] one tablet by mouth once in the morning. 2. A review of R2's medication administration record (MAR) for [redacted] revealed the [redacted] was initially administered on [redacted] 2018. R2's medical record contained no documentation of evidence to indicate an assessment of R2's behavior before initially administering the [redacted] medication was performed and the effect of the [redacted] medication administered was documented. 3. In an interview, O4 reported the medical team does not assess a resident's behavior before initially administering a [redacted] medication and the effect of the [redacted] medication administered. O4 acknowledged the facility did not contain the documentation as required in R9-10-712.C.22.d.	X12II		
X16AA	R9-10-716.A.1. Behavioral Health Services A. An administrator shall ensure that: 1. If a behavioral health residential facility is licensed to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently, a resident admitted to the behavioral health residential facility with limited ability to function independently, in addition to behavioral health services and personnel care services as indicated in the resident's treatment plan, receives continuous protective oversight; This RULE is not met as evidenced by: Based on documentation review and record	X16AA		

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X16AA	Continued From page 44 review, the administrator failed to ensure a resident with limited ability to function independently received continuous protective oversight, for five of 22 current residents sampled. Findings include: 1. A review of R2's medical record revealed R2 was under eighteen years of age and was under the guardianship of the Office of Refugee Resettlement (ORR). 2. A review of R2's electronic medical record revealed an SIR dated [redacted] 2018. The SIR stated, "UAC [unaccompanied child] reported that [R2] was in the bathroom, in the basement, by the cafeteria... UAC showed Clinician [R2's] [redacted] which showed [redacted] inch and half in length. The [redacted] appear to be [redacted] UAC stated that [R2] [redacted] a little bit and denied having any pain from the [redacted] except for when [R2] touches them. UAC reported that [R2's] classmate was bothering [R2] and that was why [R2] was triggered and decided to [redacted] 3. A review of R4's medical record revealed R4 was under eighteen years of age and was under the guardianship of the [redacted] 4. A review of R4's electronic medical record revealed a Significant Incident Report (SIR) dated [redacted] 2018. The SIR indicated R4 [redacted] 5. A review of R13's medical record revealed R13 was under eighteen years of age and was under the guardianship of the [redacted]	X16AA		

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X16AA	Continued From page 45 [redacted]	X16AA		

6. A review of R13's electronic medical record revealed an SIR dated [redacted] 2018. The SIR stated, "UAC remained quiet and then self-disclosed that [R13] engaged in [redacted] during class time and reported [R13] utilized a [redacted] Please see UAC Documents on Portal) on [R13's] [redacted] UAC reported [R13] engaged in [redacted] due to [redacted] Please note, observation logs were observed for [redacted] 8. No documentation was provided in which UAC [redacted] however, at approximately [redacted] UAC was observed [redacted] and stating that [R13] [redacted]

7. A review of R26's medical record revealed R26 was under eighteen years of age and was under the guardianship of the [redacted]

8. A review of R26's electronic medical record revealed an individual counseling note dated [redacted] 2018. The note stated, "[R26] disclosed that [R26] had [redacted] Medical reported these same [redacted] Clinician observed these same [redacted] on [R26's] [redacted] during the follow up session."

9. A review of R26's electronic medical record revealed an "Elevated Supervision" form dated [redacted] 2018. The form stated, "Client has [redacted] are observed by Clinician which are approximately [redacted] and also has additional [redacted] on [their] [redacted] and

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X16AA	Continued From page 46 [redacted] Due to the severity of possible [redacted] this incident is to be monitored for further concerns." 10. A review of R26's electronic medical record revealed an "Elevated Supervision" form dated [redacted] 2018. The form stated, "On [redacted] 2018 at [redacted]m at dispatch [R26] intentionally [redacted] on [R26's] [redacted] As [R26] continues to report [redacted] Clinician recommends an extension of 1:1 extended supervision." 11. A review of R31's medical record revealed R31 was under eighteen years of age and was under the guardianship of the [redacted] 12. A review of R31's medical record revealed a "Significant Incident Report" dated [redacted] 2018. The significant incident report stated, "Clinician met with [R31] to follow up due to [shift supervisor] informing clinician that the [staff] assigned to [R31's] class noticed a [redacted]. On [redacted] 2018, [R31] reported the [redacted] with [R31's] [redacted] Clinician observed a [redacted] t appeared to be [redacted]	X16AA		
X16AI	R9-10-716.A.3. Behavioral Health Services A. An administrator shall ensure that: 3. Behavioral health services are provided to meet the needs of a resident and are consistent with a behavioral health residential facility's scope of services; This RULE is not met as evidenced by:	X16AI		

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X16AI	Continued From page 47 Based on documentation review, record review, and interview, the administrator failed to ensure behavioral health services were provided to meet the needs of the resident and were consistent with the facility's scope of services. Findings include: 1. A review of the facility's policies and procedures revealed a policy titled, "Program Description." The policy stated, "As a behavioral health residential facility, Southwest Key Programs provides accommodations where the client receives: ... c. Individual and group counseling provided on-site by a qualified behavioral health professional... Counseling according to BRFL [Bureau of Residential Facilities]; R9-10-716 (B) is provided on-site per the following guidelines:...3. Counseling services are provided by a Clinician or Youth Care Worker who addresses behaviors, concerns and progress in reference to the client's overall psychosocial functioning." The policy and procedure manual indicated it was reviewed and approved in August 2018. 2. A review of R2's electronic medical record revealed a Significant Incident Report (SIR) dated [redacted] 2018 which indicated R2 [redacted] from [redacted] An SIR dated [redacted] 2018 revealed R2 had [redacted] using a [redacted] An SIR dated [redacted] 2018 indicated R2 suffered from [redacted] 3. A review of R2's electronic medical record revealed R2 was [redacted] on [redacted] 2018 and indicated R2 was a [redacted] for [redacted] on [redacted] 2018.	X16AI		

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X16AI	Continued From page 48 4. A review of R2's electronic medical record revealed R2 reported to the behavioral health technician on [redacted] 2018 that R2's [redacted] used to [redacted] R2 with a [redacted] over the [redacted] and it was bothering R2. However, there was no documentation of evidence to indicate a qualified behavioral health professional provided individual and group counseling related to R2's behaviors, concerns, and progress in reference to R2's overall functioning as indicated in the policies and procedures. 5. A review of R2's electronic medical record revealed a Clinical individual service plan dated [redacted] 2018 which was signed by a behavioral heath professional on [redacted] 2018. There was no documentation of evidence to indicate [redacted] and the [redacted] would be addressed during counseling sessions. 6. A review of R4's electronic medical record revealed an SIR dated [redacted] 2018. The SIR indicated R4 [redacted] 7. A review of R4's electronic medical record revealed individual counseling was performed on [redacted] 2018. There was no documentation of evidence to indicate [redacted] was addressed due to the SIR dated [redacted] 2018. 8. A review of R6's electronic medical record revealed an SIR dated [redacted] 2018 which indicated R6 had [redacted] An SIR dated [redacted] 2018 indicated R6 had [redacted] 9. A review of R6's electronic medical record revealed no documentaion of evidence to indicate a qualified behavioral health professional	X16AI		

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X16AI	Continued From page 49 provided individual and group counseling related to R6's [redacted] as indicated in the policies and procedures. 10. A review of R6's electronic medical record revealed no documentation of evidence to indicate [redacted] would be address during counseling session as part of the individual service plan. 11. A review of R13's electronic medical record revealed an SIR dated [redacted] 2018. The SIR stated, "UAC remained quiet and then self-disclosed that [R13] engaged in [redacted] yesterday during class time and reported [R13] utilized a [redacted] to make [redacted] Please see UAC Documents on Portal) on [R13's] [redacted] UAC reported [R13] engaged in [redacted] due to [redacted]. Please note, observation logs were observed for [redacted]18. No documentation was provided in which UAC [redacted] however, at approximately [redacted] UAC was observed [redacted] and stating that [R13] [redacted] 12. A review of R13's electronic medical record revealed individual counseling was performed on [redacted] 2018. There was no documentation of evidence to indicate [redacted] was addressed due to the SIR dated [redacted] 2018. 13. A review of R20's electronic medical record revealed an SIR dated [redacted] 2018. The SIR reported R20 stated, [redacted] when R20 was redirected to go to R20's bedroom by a youth care worker.	X16AI		

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X16AI	Continued From page 50 14. A review of R20's electronic medical record revealed individual counseling was performed on [redacted] 2018. There was no documentation of evidence to indicate [redacted] was addressed due to the SIR dated [redacted] 2018. 15. In an interview, E4 reported all case managers and clinicians are made aware of all SIR's prior to performing individual counseling and are "supposed to" address the behaviors and concerns. E4 acknowledged individual counseling notes contained no documentation of evidence to indicate the behaviors and concerns were addressed. E4 acknowledged the individual service plans do not indicate behaviors and concerns would be addressed as part of counseling provided.	X16AI		
X16BE	R9-10-716.A.5.a. Behavioral Health Services A. An administrator shall ensure that: 5. A resident does not: a. Use or have access to any materials, furnishings, or equipment or participate in any activity or treatment that may present a threat to the resident's health or safety based on the resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, or personal history; or This RULE is not met as evidenced by: Based on observation, record review, and interview, the administrator failed to ensure a resident did not have access to any furnishings that may present a threat to the resident's health or safety based on the resident's documented	X16BE		

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X16BE	Continued From page 51 diagnosis and personal history, for two of thirty-one residents sampled. Findings include: 1. The surveyors observed R20's bedroom contained two sets of bunk beds and four clothing hooks anchored into the wall in the corner of the room. 2. A review of R20's electronic medical record revealed a Significant Incident Report (SIR) dated [redacted] which indicated R20 stated, [redacted] when R20 was redirected to go to R20's bedroom by a youth care worker. An SIR dated [redacted] 2018 stated. "[youth care worker] notified [shift leader] about a comment that [R20] made..."I don't know why I crossed the desert.[redacted] 3. The surveyors observed R31's bedroom contained four clothing hooks anchored into the wall in the corner of the room. 4. A review of R31's electronic medical record revealed an SIR dated [redacted] 2018. The SIR stated, "[R31] asked [youth care worker] for a hair tie. [Youth care worker] asked [R31] what [R31] needed it for, [R31] stated [R31] wanted the hair tie[redacted] 5. In an interview, O2 reported all bedrooms had the hooks. 6. The surveyor later observed R20 receiving one to one supervision and the clothing hooks were removed from R20's bedroom.	X16BE		

ADHS LICENSING SERVICES

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	BH4497	A. BUILDING: _____ B. WING _____	C 10/20/2018

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X22DA	Continued From page 52	X22DA		
X22DA	R9-10-722.B.5.a. Physical Plant Standards B. An administrator shall ensure that: 5. A resident bathroom provides privacy when in use and contains: a. A shatter-proof mirror, unless the resident's treatment plan allows for otherwise; This RULE is not met as evidenced by: Based on observation, record review, interview, and documentation review, the administrator failed to ensure resident bathrooms contained a shatter-proof mirror. Findings include: 1. The surveyors observed no evidence to suggest the mirrors in the resident bathrooms were shatter-proof. The surveyors observed a film on the mirrors. 2. A review of R2's treatment plan revealed no documentation allowing for a bathroom mirror to not be shatter-proof. 3. A review of R13's treatment plan revealed no documentation allowing for a bathroom mirror to not be shatter-proof. 4. A review of R26's treatment plan revealed no documentation allowing for a bathroom mirror to not be shatter-proof. 5. A review of R31's treatment plan revealed no documentation allowing for a bathroom mirror to not be shatter-proof. 6. A review of R2's electronic medical record revealed a Significant Incident Report (SIR) dated [redacted]2018. The SIR stated, "UAC	X22DA		

ADHS LICENSING SERVICES

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X22DA	Continued From page 53 [Unaccompanied Child] reported [R2] was having [redacted] today about wanting to [redacted] Clinician asked if UAC had any [redacted] and UAC reported [R2's] [redacted] was to [redacted] in order to [redacted] UAC reported thoughts of [redacted] started approximately one year... UAC also reported a history of [redacted] since the age of [redacted] 7. A review of R2's electronic medical record revealed a psychiatric assessment from [redacted] Hospital dated [redacted] 2018. The assessment stated, [redacted] 8. A review of R2's electronic medical record revealed an SIR dated [redacted] 2018. The SIR stated, "UAC reported that [R2] was in the bathroom, in the basement, by the cafeteria... UAC showed Clinician [R2's] [redacted] which showed [redacted] The [redacted] and [redacted] UAC stated that [R2] [redacted] a little bit and denied having any [redacted] except for when [R2] [redacted] UAC reported that [R2's] classmate was bothering [R2] and that was why [R2] was triggered and decided to [redacted] 9. A review of R13's electronic medical record revealed an SIR dated [redacted] 2018. The SIR stated, "UAC remained quiet and then self-disclosed that [R13] engaged in [redacted] yesterday during class time and reported [R13] [redacted] to make [redacted] Please see UAC Documents on Portal) on [R13's] [redacted] UAC reported [R13] engaged in [redacted] due to	X22DA		

ADHS LICENSING SERVICES

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X22DA	Continued From page 54 [redacted] Please note, observation logs were observed for [redacted]18. No documentation was provided in which UAC [redacted] however, at approximatel[redacted] UAC was observed [redacted] and stating that [R13[redacted] 10. A review of R26's electronic medical record revealed a individual counseling note dated [redacted] 2018. The note stated, "[R26] disclosed that [R26] had [redacted] to [redacted] Medical reported these same [redacted] Clinician observed these same four [redacted] on [R26's] [redacted] during the follow up session." 11. A review of R26's electronic medical record revealed an "Elevated Supervision" form dated [redacted] 2018. The form stated, "Client has [redacted] 2 [redacted]re observed by Clinician which are [redacted] and also has additional [redacted] and [redacted] Due to the severity of possible [redacted] [redacted] his incident is to be monitored for further concerns." 12. A review of R26's electronic medical record revealed an "Elevated Supervision" form dated [redacted] 2018. The form stated, "On [redacted] 2018 a[redacted] at dispatch [R26] [redacted] on [R26's] [redacted] As [R26] continues to report [redacted] [redacted] Clinician recommends an extension of 1:1 extended supervision." 13. A review of R31's medical record revealed a "Significant Incident Report" dated [redacted] 2018. The significant incident report stated, "Clinician met with [R31] to follow up due to [shift supervisor] informing clinician that the [staff]	X22DA		

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X22DA	Continued From page 55 assigned to [R31's] class noticed a [redacted] On [redacted] 2018, [R31] reported the [redacted] with [R31's] [redacted] Clinician observed a [redacted] into [R31's] [redacted] it appeared to be [redacted] 14. In an interview, O2 reported the mirrors in resident bathrooms had a film on them. O2 explained they were recently made aware that the film was not acceptable. O2 reported a company came out the week prior to give a quote on shatter-proof mirrors. 15. A review of facility documentation revealed the facility received an estimate from one company on October 18, 2018. 16. In an interview, O1 reported the facility would need to get two other bids before they could have the shatter-proof mirrors installed.	X22DA		
X22EU	R9-10-722.B.8.e. Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: e. Has window or door covers that provide resident privacy; This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure a resident bedroom had window or door covers that provided resident privacy. Findings include: 1. The surveyors observed the windows to	X22EU		

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X22EU	Continued From page 56 several bedrooms did not have adequate coverage to provide resident privacy. Room 410 had a window with broken and missing slats. Rooms 232 and 235 had a window with blinds that were not able to be lowered. Rooms 215, 216, 218, 219, 220, 221, 222, and 224 had windows in the wall directly next to the door entering the bedroom where anyone walking down the hallway could see into the bedroom. Bedrooms 217A, 310, 411, 412, 405, 406, 515, and 518 had windows in the door with no covers. 2. The surveyor observed the entry doors to rooms 430, 426, and 423 were sliding glass doors. The surveyor observed the doors did not have covers to provide resident privacy. 3. In an interview, O2 acknowledged the windows and doors did not have covers to provide privacy. O2 later reported they were covering the windows and doors.	X22EU		
X22GI	R9-10-722.B.8.i. Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: i. Has clean linen for each bed including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each resident; This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure each resident's bed had a mattress pad.	X22GI		

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X22GI	Continued From page 57 Findings include: 1. The surveyors spot-checked beds in the following bedrooms and none of the beds had a mattress pad: Rooms 505, 509, 514, 517, 524, 528, 501, 503, 420, 416, 410, 407, 430, 426, 423, 312, 317, 320, 322, 326, 329, 225, 216, 213, and 222. 2. In an interview, O2 acknowledged the beds did not have a mattress pad. O2 later reported the facility ordered mattress pads for the beds.	X22GI		